Michigan WIC Special Formula/Food Request Form

Client: _____ DOB: _____ Parent/Guardian: _____

1. QUALIFYING MEDICAL CONDITION(S):

☐ Premature birth < 37 weeks gestation
☐ Failure to thrive
☐ Severe food allergies (Specify) _____
☐ Immune system disorder (Specify) _____
☐ Metabolic disorder/inborn errors of metabolism (Specify) _____
☐ Medical condition that impairs nutrition status (Specify) _____
☐ Gastrointestinal disorder/malabsorption syndromes (Specify) _____

Conditions such as rash, non-specific intolerance, underweight, fussiness, colic, spitting-up, vomiting, gas and constipation will **NOT** be considered indications for a special formula. **Please specify the underlying medical condition.**

2. FORMULA: _____ **AMOUNT:** ☐ Maximum ***OR*** _____ oz /day

Note: Soy beverages should be requested in Section 4 below.

A list of Michigan Authorized Formulas is available at: *www.michigan.gov/WIC* Click on Link: Medical Providers

3. SUPPLEMENTAL WIC FOODS: (*CHECK ONE*; *MUST BE COMPLETED FOR ALL FORMULA REQUESTS*)

☐ **All** (Issue all allowed **age appropriate** WIC Foods starting at six months)

☐ **Restriction (Check foods to be OMITTED):**

Infant (6-12 months)	**Child (1- 5 Years) and Woman**	**Special Instructions/Comments:**
□ All (Issue formula only)	□ All (Issue formula only)	
□ Infant cereal	□ Milk	_____
□ Infant fruits/vegetables	□ Cheese	
	□ Eggs	_____
	□ Legumes	
	□ Peanut butter	_____
	□ Breakfast cereal	
	□ Bread, rice, tortilla, oatmeal	_____
	□ Fresh fruits/vegetables	
	□ 100% fruit/vegetable juice	_____
	□ Canned fish (women only)	

4. FOOD SUBSTITUTIONS (Optional): (*ALLOWED ONLY WITH APPROPRIATE MEDICAL CONDITION)*

☐ **Whole milk** (woman/child ≥ 2 yrs): If medically indicated formula prescribed and extra calories needed.

☐ **Cheese in place of milk:** ☐ Maximum ***OR*** ☐ Other amount (specify):_____

☐ **Soy Beverage in place of milk/cheese for child with:**

☐ Milk protein allergy ☐ Severe lactose intolerance ☐ Vegetarian/Vegan diet ☐ Other: _____

5. DURATION:

☐ 1 month ☐ 2 months ☐ 3 months ☐ 4 months ☐ 5 months ☐ 6 months *(maximum approval)*

Medical Provider Name:	**WIC Use Only** Client # (Optional)
Address:	Approved Through (Optional):
Phone: **Fax:**	Reason (If Denied):
Signature: **Date:**	Signature (If Denied): Date:

WIC CLINIC: _____ **Phone**: _____ **Fax**: _____